Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders

Overview Paper 2

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

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SUMMARY

Screening, assessment, and treatment planning (see Table 1, Key Definitions) constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons with co-occurring disorders (COD). Clients with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other. This paper discusses the purpose, appropriate staffing, protocols, methods, advantages and disadvantages, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and financing.

INTRODUCTION

Screening and assessment instruments are tools for information gathering, as are laboratory tests. However, the use of these tools alone does not constitute screening or assessment. Screening and assessment must allow flexibility within their formalized structures, balancing the need for consistency with the need to respond to important differences among clients. Screening and assessment data provide information that is evaluated and processed by the clinician and the client in the treatment planning process.

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a process that may be conducted by different agencies. Effective information sharing and following of clients most frequently occurs in systems where relevant agencies have a formal network, cross-training for staff, and formal procedures for information sharing and referral.

LITERATURE HIGHLIGHTS

Integrated screening, assessment, and treatment planning (see Table 1, Key Definitions):

> . . . begins at the earliest point of contact with the client, [and] continues through the relapse prevention stage. Information regarding a client's substance abuse and functional adjustment is gathered throughout the treatment process, along with evidence regarding the effects of interventions (or lack thereof). Treatment plans are then modified accordingly (Mueser et al., 2003, p. 49).

A compendium of relevant COD screening and assessment instruments can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Appendixes G and H, pages 487–512 (Center for Substance Abuse Treatment [CSAT], 2005).

Table 1: Key Definitions

Screening	Determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
Assessment	Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
Treatment Planning	Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.
Integrated Screening, Assessment, and Treatment Planning	Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.

A vast amount of literature exists on screening, assessment, and treatment planning in substance abuse treatment and an equally vast amount in mental health settings. Considerably less material has been published on screening, assessment, and treatment planning specifically addressing persons with (or suspected of having) COD. However, a clinically meaningful and useful screening, assessment, and treatment planning process will necessarily include procedures, practices, and tools drawn from both the substance abuse and mental health fields.

Clients with COD are best served when screening, assessment, and treatment planning are integrated, addressing both substance abuse and mental health disorders, each in the context of the other. Diagnostic certainty cannot be the basis for service planning and design, and COCE encourages the use of a broad definition of COD based on client service needs. For example, some clients' mental health and substance abuse problems may not, at a given point in time, fully meet the criteria for diagnoses in categories from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). Nonetheless, they would be included in a broad definition of COD to allow responses to the real needs of consumers.

The process of integrated screening, assessment, and treatment planning will vary depending on the information available at the time of initial contact with the client. The special challenge of screening, assessment, and treatment planning in COD is to explore, determine, and respond to the effects of two mutually interacting disorders. Because neither substance abuse nor mental illness should be considered primary for a person with COD (Lehman et al., 1998; Mueser et al., 2003), an existing diagnosis of mental illness or substance abuse is a point of departure only.

The complexity of COD dictates that screening, assessment, and treatment planning cannot be bound by a rigid formula. Rather, the success of this process depends on the skills and creativity of the clinician in applying available procedures, tools, and laboratory tests and on the relationships established with the client and his or her intimates.

KEY QUESTIONS AND ANSWERS

Overview Question

1. How do screening, assessment, and treatment planning relate to one another?

Figure 1 (page 3) summarizes the relationships among screening, assessment, and treatment planning and their usual ordering in time. Note the iterative relationship between treatment planning and assessment. Rather than being one-time events, these activities constitute a process of continual refinement and adaptation to changing client circumstances. Figure 1 introduces the concept of *Contact* (see left-hand side of the figure), which refers to the fact that there is "no wrong door" through which a client can enter the COD system of care. The capacity for screening and the ability to recognize that some form of assistance is required should be available at any point in the service system (CSAT, 2000).

Integrated Screening (see Table 1, Key Definitions, page 1)

1. What is the purpose of integrated screening?

Integrated screening addresses both mental health and substance abuse, each in the context of the other disorder. Integrated screening seeks to answer a yes/no question: "Is there sufficient evidence of a substance use and/or other mental disorder to warrant further exploration?" A comprehensive screening process also includes exploration of a variety of related service needs including medical, housing, victimization, trauma, and so on. In other words, screening expedites entry into appropriate services. At this point in the screening, assessment, and treatment planning process, the goal is to identify everyone who *might* have COD and related service needs.

2. Who is responsible for integrated screening and in what settings does it occur?

There are seldom any legal or professional restraints on who can be trained to conduct a screening. If properly trained staff are available, integrated screening can occur in any health or human services context as well as within the criminal justice, homeless services, and educational systems. The broader the range of relevant contexts in which screening can occur in a given community, the greater the probability that persons with COD will be identified and referred for further assessment and treatment. Ideally, screening should take place in a wide variety of settings.

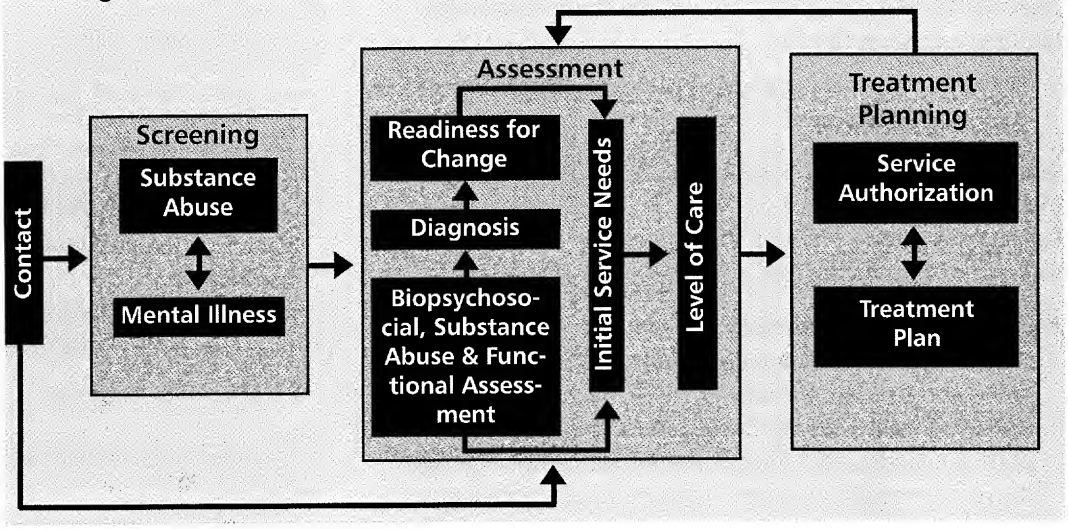
3. What protocols are allowed in conducting an integrated screening?

Any screening protocols, including integrated screening, must specify the methods to be followed and the questions to be asked. If tools or instruments are to be used, integrated screening protocols must indicate what constitutes scoring positive for a specific potential problem (often called "establishing cut-off scores"). Additionally, the screening protocol must detail exactly what is to take place when the client scores in the positive range (e.g., where the client is to be referred for further assessment). Finally, a screening protocol should provide a format for recording the results of the screening, other relevant client information, and the disposition of the case. See also TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005).

4. *What methods are used to conduct an integrated screening?*

Information-gathering methods for screening may include screening instruments, laboratory tests, clinical interviews, and personal contact. The circumstances of contact, the client's demeanor and behavior, signs of acute intoxication, physical signs suggesting drug use or attempts at self-harm, and information offered spontaneously by the client or intimates can be indicators of substance use and/or mental disorders.

Figure 1: Relationships Among Screening, Assessment, and Treatment Planning



5. *What are the advantages and disadvantages of screening instruments?*

Screening instruments can be an efficient form of information gathering. **A compendium of relevant screening instruments can be found in TIP 42, Appendixes G and H, pages 487–512 (CSAT, 2005).** The advantages of using screening tools are the simplicity of their use and scoring, the generally limited training needed for their administration, and, for well-researched tools, a known level of reliability and the availability of cut-off scores. One disadvantage of screening instruments is that they sometimes become the *only* component of the screening process. A second disadvantage is that a routinely administered screening instrument provides little opportunity to establish a connection with the client. Such a connection may be important in motivating the client to accept a referral for assessment if needed.

6. *Is there one right integrated screening process for all clients?*

Both the screening process and the interpretation of screening information will depend on the client's language of preference, culture, and age. For all of these reasons, the screening process must allow flexibility within its formalized structure, balancing the need for consistency with the need to respond to important differences among clients.

Integrated Assessment (see Table 1, Key Definitions, page 1)

1. *What is the purpose of integrated assessment?*

Like integrated screening, integrated assessment addresses both mental health and substance abuse, each in the context of the other disorder. Integrated assessment seeks to (1) establish formal diagnoses (see the COCE Overview Paper titled "Definitions and Terms Relating to Co-Occurring Disorders"), (2) evaluate level of functioning (i.e., current cognitive capacity, social skills, and other abilities) to identify factors that could interfere with the ability to function independently and/or follow treatment recommendations, (3) determine the client's readiness for change, and (4) make initial decisions about appropriate level of care. Integrated assessment also should consider cultural and linguistic issues, amount of social support, special life circumstances (e.g., women with children), and medical conditions (e.g., HIV/AIDS, tuberculosis) that may affect services choices and the client's ability to profit from them.

The assessment process should be client-centered in order to fully motivate and engage the client in the assessment and treatment process. *Client-centered* means that the client's perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it.

2. *Who is responsible for integrated assessment, and in what settings does it occur?*

Integrated assessment may be conducted by any mental health or substance abuse professional who has the specialized training and skills required. DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, clinical psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental disorders. Note that certain assessment instruments can only be obtained and administered by a licensed psychologist. In some cases (e.g., persons without a confirmed diagnosis of either a substance use or mental health disorder, and persons with additional special needs such as homeless or dependent adults), an assessment team including substance abuse and mental health professionals and other service providers may be needed to complete the assessment. Generally, assessment occurs in a mental health or substance abuse treatment

facility. In some cases, communities or large systems within communities (e.g., the corrections system) may establish free-standing assessment centers.

3. *What protocols are followed in conducting an integrated assessment?*

As shown in Table 2, there are 12 specific steps in the assessment process. Chapter 4 in TIP 42 (CSAT, 2005) describes these steps in detail. Through these steps, the assessment seeks to accomplish the following aims:

- Obtain a detailed chronological history of past symptoms, diagnoses, treatment, and impairment for both mental health and substance abuse.
- Obtain a detailed description of current strengths, supports, limitations, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
- Determine stage of change for *each problem*. (If a clinician is asked, "What stage of change is the client in?" the correct answer is *always*, "For which problem?")
- Identify social supports and other factors that might help promote treatment adherence.
- Find out what clients want, in terms of their perception of the problem, what they want to change, and how they think that change will occur.

The assessment for COD is integrated by analyzing data concerning one disorder in light of data concerning the other disorder. For example, attention to mental health symptoms, impairments, diagnoses, and treatments during past episodes of substance abuse and abstinence can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder.

4. *What methods are used to conduct an integrated assessment?*

An assessment may include a variety of information-gathering methods including the administration of assessment instruments, an in-depth clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination, and laboratory tests (toxicology screens, tests for infectious diseases and organ system damage, etc.).

5. *What are the advantages and disadvantages of assessment instruments?*

Assessment instruments constitute a structured method for gathering information in many areas, and for establishing assessment scores that define problem areas. **Appendix G, pages 487–495 of TIP 42 (CSAT, 2005) provides relevant examples of instruments that may be used in the assessment of COD.** Assessment instruments also can function as "ticklers" or memory aids to the clinician or team, assisting in making sure that all relevant topics are covered.

Table 2: The 12-Step Assessment Process

1. Engage the client
2. Upon receipt of appropriate client authorization(s), identify and contact collaterals (family, friends, other treatment providers) to gather additional information
3. Screen for and detect COD
4. Determine severity of mental and substance use disorders
5. Determine appropriate care setting (e.g., inpatient, outpatient, day-treatment)
6. Determine diagnoses
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify additional problem areas to address (e.g., physical health, housing, vocational, educational, social, spiritual, cognitive, etc.)
11. Determine readiness for change
12. Plan treatment

Assessment instruments should be viewed as providing information that is part of the assessment process. They do not themselves constitute an assessment. In particular, instruments do not accomplish the interpersonal goals of assessment: making the client feel welcome in the treatment system, engaging the client as an active partner in his or her care, and beginning the therapeutic alliance that will exist throughout the client's relationship with helping resources.

6. *Is there one correct integrated assessment process for all clients?*

No, there is not. The integrated assessment process must be tailored to the needs of the specific client. For example:

- Cultural identity may play a significant role in determining the client's (and his or her intimates') view of the problem and the treatment. Ethnic culture may affect perception of what constitutes a "problem," the meaning of help seeking, and attitudes toward caregivers and institutions.
- Members of some nonethnic subcultures (e.g., sex workers, gang members) may hold beliefs and values that are unfamiliar to nonmembers.
- Clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, various alternative healing practices) that affect how they view treatment and treatment providers.
- A client's sexual orientation and family situation will enhance understanding of the client's personal identity, living situation, and relationships.

Integrated Treatment Planning (See Table 1, Key Definitions, page 1)

1. *What is the process of integrated treatment planning, and how does this process relate to integrated screening and assessment?*

Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. During integrated treatment planning phases, initial decisions are made about what services the client needs and wants, where these services will be provided, who will share responsibility with the client for monitoring progress, how the services of different providers will be coordinated, and how services will be reimbursed. The latter will sometimes involve seeking service authorization to obtain reimbursement, which may, in turn, place constraints on the treatment plan or require revisions of it. Treatment planning should be client centered, addressing clients' goals and using treatment strategies that are acceptable to them.

Screening and assessment data provide information that is integrated by the clinician and the client in the treatment planning process. Screening and assessment data also are useful in establishing a client's baseline of signs, symptoms, and behaviors that can then be used to assess progress.

Table 3 (adapted from Mueser et al., 2003) describes the components of a client-centered treatment plan. The treatment plan is never a static document. As changes in the client's status occur and as new relevant information comes to light, the treatment plan must be reconsidered and adjusted.

2. *Who is responsible for integrated treatment planning?*

The client-centered treatment plan is the joint responsibility of the clinician or clinical team and *the client*. The client-centered plan is guided by what the client wishes to accomplish and the methods that are acceptable to him or her. In systems where care is managed, some aspects of the plan may require authorization by payors. Securing service authorization is the responsibility of the providers. If a provider is unable to obtain service authorization, the client and the provider should explore together what possible modifications to the treatment plan will best meet the client's needs and satisfy reimbursement requirements.

Systems Issues and Financing

1. *Why is service integration crucial to screening, assessment, and treatment planning?*

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a treatment process. Screening, assessment, and treatment planning may be conducted by multiple agencies. Information must be shared accurately and efficiently between agencies, while conforming to Federal confidentiality laws. Equally important, making referrals among agencies requires monitoring to ensure that clients referred actually arrive at the referral site and receive needed services. Effective information sharing and tracking of clients most likely occurs in systems where relevant agencies have formal relationships (e.g., memoranda of understanding), receive cross-training,

Table 3: The Components of a Client-Centered Treatment Plan (adapted from Mueser et al., 2003)

Acute Safety Needs	Determines the need for immediate acute stabilization to establish safety prior to routine assessment
Severity of Mental and Substance Use Disorders	Guides the choice of the most appropriate setting for treatment
Appropriate Care Setting	Determines the client's program assignment (see American Society of Addiction Medicine, 2001)
Diagnosis	Determines the recommended treament intervention
Disability	Determines case management needs and whether an enhanced level of intervention is required
Strengths and Skills	Determines areas of prior success around which to organize future treatment interventions and determines areas of skill-building needed for management of either disorder
Availability and Continuity of Recovery Support	Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning
Cultural Context	Determines most culturally appropriate treatment interventions and settings
Problem Priorities	Determines problems to be solved specifically, and opportunities for contingencies to promote treatment participation
State of Recovery/ Client's Readiness to Change Behaviors Relating to Each Problem	Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness for change (see TIP 35, *Enhancing Motivation for Change in Substance AbuseTreatment* [CSAT, 1991])

and have formal procedures for information sharing and referral.

2. *How are screening, assessment, and treatment planning reimbursed?*

In healthcare settings (mental health, substance abuse, primary care, etc.), screening may be reimbursed as part of an initial visit. In other settings (criminal justice, schools, homeless services), screening activities are not likely to be "reimbursed" as they are usually conducted by a salaried employee (e.g., probation officer, school psychologist) who is performing screening services on behalf of an agency that mandates or allows screening to be conducted in the ordinary course of its business.

Assessment is a necessary part of treatment and accordingly may be reimbursed as part of the services provided by a qualified treatment program. However, cases may arise in which the costs of assessment are not completely reimbursable.

In some instances, not all treatment services required by persons with COD will be reimbursable or reimbursable at intensities or durations commensurate with the integrated treatment plan. Significant variations exist within States and among health plans concerning the nature and type of behavioral health services that are covered. In cases where reimbursement is unavailable or inadequate, providers must arrive at alternate treatment plans in concert with their clients, and document the adequacy and goals of the alternate plan.

3. *What is the legal exposure for a program that identifies problems in the screening and assessment process for which the program cannot provide treatment?*

Not all programs are expected to be able to treat every type of disorder, even if those disorders are identified by the program's screening and assessment procedures. To avoid negative legal consequences and fulfill ethical obligations to clients, at a minimum, programs must be able to refer clients with identified disorders or combinations of disorders for appropriate treatment.

FUTURE DIRECTIONS

The technology of screening, assessment, and treatment planning for COD is constantly under refinement. One pressing need is for screening, assessment, and treatment planning protocols that are designed to meet the needs of a variety of special populations, including adolescents; lesbian, gay, and bisexual individuals; women with children; and older adults. The processes of knowledge transfer and adoption must also be better refined to facilitate the widespread and informed use of valid and reliable screening and assessment instruments, and treatment planning protocols.

At the system level, policies and regulations can encourage standardized, integrated screening, assessment, and treatment planning processes to increase the provision of appropriate services to people with COD and to enable outcomes-monitoring across programs. Encouraging trends in this regard are to be found in several States that are moving toward statewide screening and assessment standards.

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